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CS/HB 7107, Engrossed 3

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1 A bill to be entitled

2 An act relating to Medicaid managed care; creating part IV

3 of ch. 409, F.S., entitled "Medicaid Managed Care";

4 creating s. 409.961, F.S.; providing for statutory

5 construction; providing applicability of specified

6 provisions throughout the part; providing rulemaking

7 authority for specified agencies; creating s. 409.962,

8 F.S.; providing definitions; creating s. 409.963, F.S.;

9 designating the Agency for Health Care Administration as

10 the single state agency to administer the Medicaid

11 program; providing for specified agency responsibilities;

12 requiring client consent for release of medical records;

13 creating s. 409.964, F.S.; establishing the Medicaid

14 program as the statewide, integrated managed care program

15 for all covered services; authorizing the agency to apply

16 for and implement waivers; providing for public notice and

17 comment; creating s. 409.965, F.S.; providing for

18 mandatory enrollment; providing exemptions; creating s.

19 409.966, F.S.; providing requirements for eligible plans

20 that provide services in the Medicaid managed care

21 program; establishing provider service network

22 requirements for eligible plans; providing for eligible

23 plan selection; requiring the agency to use an invitation

24 to negotiate; requiring the agency to compile and publish

25 certain information; establishing regions for separate

26 procurement of plans; providing quality criteria for plan

27 selection; providing limitations on serving recipients

28 during the pendency of procurement litigation; creating s.

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409.967, F.S.; providing for managed care plan accountability; establishing contract terms; providing for physician compensation; providing for emergency services; establishing requirements for access; requiring a drug formulary or preferred drug list; requiring plans to accept requests for service electronically; requiring the agency to maintain an encounter data system; requiring plans to provide encounter data; requiring the agency to establish performance standards for plans; providing program integrity requirements; establishing requirements for the database; establishing a grievance resolution process; providing penalties for early termination of contracts or reduction in enrollment levels; establishing prompt payment requirements; requiring fair payment to providers with a controlling interest in a provider service network by other plans; requiring itemized payment; providing for dispute resolutions between plans and providers; providing for achieved savings rebates to plans; creating s. 409.968, F.S.; establishing managed care plan payments; providing payment requirements for provider service networks; requiring the agency to conduct annual cost reconciliations to determine certain cost savings and report the results of the reconciliations to the fee-for-service provider; prohibiting rate increases that are not authorized in the appropriations act; creating s. 409.969, F.S.; requiring enrollment in managed care plans by all nonexempt Medicaid recipients; creating requirements for plan selection by recipients; authorizing

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disenrollment under certain circumstances; defining the term "good cause" for purposes of disenrollment; providing time limits on an internal grievance process; providing requirements for agency determination regarding disenrollment; requiring recipients to stay in plans for a specified time; creating s. 409.97, F.S.; authorizing the agency to accept the transfer of certain revenues from local governments; requiring the agency to contract with a representative of certain entities participating in the low-income pool for the provision of enhanced access to care; providing for support of these activities by the low-income pool as authorized in the General Appropriations Act; establishing the Access to Care Partnership; requiring the agency to seek necessary waivers and plan amendments; providing requirements for prepaid plans to submit data; authorizing the agency to implement a tiered hospital rate system; creating s. 409.971, F.S.; creating the managed medical assistance program; providing deadlines to begin and finalize implementation of the program; creating s. 409.972, F.S.; providing eligibility requirements for mandatory and voluntary enrollment; creating s. 409.973, F.S.; establishing minimum benefits for managed care plans to cover; authorizing plans to customize benefit packages; requiring plans to establish programs to encourage healthy behaviors and establish written agreements with certain enrollees to participate in such programs; requiring plans to establish a primary care initiative; providing

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85 requirements for primary care initiatives; requiring plans
86 to report certain primary care data to the agency;
87 creating s. 409.974, F.S.; establishing a deadline for
88 issuing invitations to negotiate; establishing a specified
89 number or range of eligible plans to be selected in each
90 region; establishing quality selection criteria;
91 establishing requirements for participation by specialty
92 plans; establishing the Children's Medical Service Network
93 as an eligible plan; creating s. 409.975, F.S.; providing
94 for managed care plan accountability; authorizing plans to
95 limit providers in networks; requiring plans to include
96 essential Medicaid providers in their networks unless an
97 alternative arrangement is approved by the agency;
98 identifying statewide essential providers; specifying
99 provider payments under certain circumstances; requiring
100 plans to include certain statewide essential providers in
101 their networks; requiring good faith negotiations;
102 specifying provider payments under certain circumstances;
103 allowing plans to exclude essential providers under
104 certain circumstances; requiring plans to offer a contract
105 to home medical equipment and supply providers under
106 certain circumstances; establishing the Florida medical
107 school quality network; requiring the agency to contract
108 with a representative of certain entities to establish a
109 clinical outcome improvement program in all plans;
110 providing for support of these activities by certain
111 expenditures and federal matching funds; requiring the
112 agency to seek necessary waivers and plan amendments;

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113 providing for eligibility for the quality network;
114 requiring plans to monitor the quality and performance
115 history of providers; establishing the MomCare network;
116 requiring the agency to contract with a representative of
117 all Healthy Start Coalitions to provide certain services
118 to recipients; providing for support of these activities
119 by certain expenditures and federal matching funds;
120 requiring plans to enter into agreements with local
121 Healthy Start Coalitions for certain purposes; requiring
122 specified programs and procedures be established by plans;
123 establishing a screening standard for the Early and
124 Periodic Screening, Diagnosis, and Treatment Service;
125 requiring managed care plans and hospitals to negotiate
126 rates, methods, and terms of payment; providing a limit on
127 payments to hospitals; establishing plan requirements for
128 medically needy recipients; creating s. 409.976, F.S.;
129 providing for managed care plan payment; requiring the
130 agency to establish payment rates for statewide inpatient
131 psychiatric programs; requiring payments to managed care
132 plans to be reconciled to reimburse actual payments to
133 statewide inpatient psychiatric programs; creating s.
134 409.977, F.S.; providing for automatic enrollment in a
135 managed care plan for certain recipients; establishing
136 opt-out opportunities for recipients; creating s. 409.978,
137 F.S.; requiring the agency to be responsible for
138 administering the long-term care managed care program;
139 providing implementation dates for the long-term care
140 managed care program; providing duties of the Department

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141 of Elderly Affairs relating to assisting the agency in
142 implementing the program; creating s. 409.979, F.S.;
143 providing eligibility requirements for the long-term care
144 managed care program; creating s. 409.98, F.S.;
145 establishing the benefits covered under a managed care
146 plan participating in the long-term care managed care
147 program; creating s. 409.981, F.S.; providing criteria for
148 eligible plans; designating regions for plan
149 implementation throughout the state; providing criteria
150 for the selection of plans to participate in the long-term
151 care managed care program; providing that participation by
152 the Program of All-Inclusive Care for the Elderly and
153 certain Medicare plans is pursuant to an agency contract
154 and not subject to procurement; creating s. 409.982, F.S.;
155 requiring the agency to establish uniform accounting and
156 reporting methods for plans; providing for mandatory
157 participation in plans by certain service providers;
158 authorizing the exclusion of certain providers from plans
159 for failure to meet quality or performance criteria;
160 requiring plans to monitor participating providers using
161 specified criteria; requiring certain providers to be
162 included in plan networks; providing provider payment
163 specifications for nursing homes and hospices; creating s.
164 409.983, F.S.; providing for negotiation of rates between
165 the agency and the plans participating in the long-term
166 care managed care program; providing specific criteria for
167 calculating and adjusting plan payments; allowing the
168 CARES program to assign plan enrollees to a level of care;

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169 providing incentives for adjustments of payment rates;
170 requiring the agency to establish nursing facility-
171 specific and hospice services payment rates; creating s.
172 409.984, F.S.; providing criteria for automatic
173 assignments of plan enrollees who fail to choose a plan;
174 providing for hospice selection within a specified
175 timeframe; providing for a choice of residential setting
176 under certain circumstances; creating s. 409.9841, F.S.;
177 creating the long-term care managed care technical
178 advisory workgroup; providing duties; providing
179 membership; providing for reimbursement for per diem and
180 travel expenses; providing for repeal by a specified date;
181 creating s. 409.985, F.S.; providing that the agency shall
182 operate the Comprehensive Assessment and Review for Long-
183 Term Care Services program through an interagency
184 agreement with the Department of Elderly Affairs;
185 providing duties of the program; defining the term
186 "nursing facility care"; providing for severability;
187 providing an effective date.

188
189 Be It Enacted by the Legislature of the State of Florida:

190
191 Section 1. Sections 409.961 through 409.985, Florida
192 Statutes, are designated as part IV of chapter 409, Florida
193 Statutes, entitled "Medicaid Managed Care."

194 Section 2. Section 409.961, Florida Statutes, is created
195 to read:

196 409.961 Statutory construction; applicability; rules.—It

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197 is the intent of the Legislature that if any conflict exists
198 between the provisions contained in this part and in other parts
199 of this chapter, the provisions in this part control. Sections
200 409.961-409.985 apply only to the Medicaid managed medical
201 assistance program and long-term care managed care program, as
202 provided in this part. The agency shall adopt any rules
203 necessary to comply with or administer this part and all rules
204 necessary to comply with federal requirements. In addition, the
205 department shall adopt and accept the transfer of any rules
206 necessary to carry out the department's responsibilities for
207 receiving and processing Medicaid applications and determining
208 Medicaid eligibility and for ensuring compliance with and
209 administering this part, as those rules relate to the
210 department's responsibilities, and any other provisions related
211 to the department's responsibility for the determination of
212 Medicaid eligibility.

213 Section 3. Section 409.962, Florida Statutes, is created
214 to read:

215 409.962 Definitions.—As used in this part, except as
216 otherwise specifically provided, the term:

217 (1) "Accountable care organization" means an entity
218 qualified as an accountable care organization in accordance with
219 federal regulations, and which meets the requirements of a
220 provider service network as described in s. 409.912(4)(d).

221 (2) "Agency" means the Agency for Health Care
222 Administration.

223 (3) "Aging network service provider" means a provider that
224 participated in a home and community-based waiver administered

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by the Department of Elderly Affairs or the community care service system pursuant to s. 430.205 as of October 1, 2013.

(4) "Comprehensive long-term care plan" means a managed care plan that provides services described in s. 409.973 and also provides the services described in s. 409.98.

(5) "Department" means the Department of Children and Family Services.

(6) "Eligible plan" means a health insurer authorized under chapter 624, an exclusive provider organization authorized under chapter 627, a health maintenance organization authorized under chapter 641, or a provider service network authorized under s. 409.912(4)(d) or an accountable care organization authorized under federal law. For purposes of the managed medical assistance program, the term also includes the Children's Medical Services Network authorized under chapter 391. For purposes of the long-term care managed care program, the term also includes entities qualified under 42 C.F.R. part 422 as Medicare Advantage Preferred Provider Organizations, Medicare Advantage Provider-sponsored Organizations, and Medicare Advantage Special Needs Plans, and the Program of All-Inclusive Care for the Elderly.

(7) "Long-term care plan" means a managed care plan that provides the services described in s. 409.98 for the long-term care managed care program.

(8) "Long-term care provider service network" means a provider service network a controlling interest of which is owned by one or more licensed nursing homes, assisted living facilities with 17 or more beds, home health agencies, community

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care for the elderly lead agencies, or hospices.

(9) "Managed care plan" means an eligible plan under contract with the agency to provide services in the Medicaid program.

(10) "Medicaid" means the medical assistance program authorized by Title XIX of the Social Security Act, 42 U.S.C. ss. 1396 et seq., and regulations thereunder, as administered in this state by the agency.

(11) "Medicaid recipient" or "recipient" means an individual who the department or, for Supplemental Security Income, the Social Security Administration determines is eligible pursuant to federal and state law to receive medical assistance and related services for which the agency may make payments under the Medicaid program. For the purposes of determining third-party liability, the term includes an individual formerly determined to be eligible for Medicaid, an individual who has received medical assistance under the Medicaid program, or an individual on whose behalf Medicaid has become obligated.

(12) "Prepaid plan" means a managed care plan that is licensed or certified as a risk-bearing entity, or qualified pursuant to s. 409.912(4)(d), in the state and is paid a prospective per-member, per-month payment by the agency.

(13) "Provider service network" means an entity qualified pursuant to s. 409.912(4)(d) of which a controlling interest is owned by a health care provider, or group of affiliated providers, or a public agency or entity that delivers health services. Health care providers include Florida-licensed health

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281 care professionals or licensed health care facilities, federally
282 qualified health care centers, and home health care agencies.

283 (15) "Specialty plan" means a managed care plan that
284 serves Medicaid recipients who meet specified criteria based on
285 age, medical condition, or diagnosis.

286 Section 4. Section 409.963, Florida Statutes, is created
287 to read:

288 409.963 Single state agency.—The agency is designated as
289 the single state agency authorized to manage, operate, and make
290 payments for medical assistance and related services under Title
291 XIX of the Social Security Act. Subject to any limitations or
292 directions provided in the General Appropriations Act, these
293 payments may be made only for services included in the program,
294 only on behalf of eligible individuals, and only to qualified
295 providers in accordance with federal requirements for Title XIX
296 of the Social Security Act and state law. This program of
297 medical assistance is designated as the "Medicaid program." The
298 department is responsible for Medicaid eligibility
299 determinations, including, but not limited to, policy, rules,
300 and the agreement with the Social Security Administration for
301 Medicaid eligibility determinations for Supplemental Security
302 Income recipients, as well as the actual determination of
303 eligibility. As a condition of Medicaid eligibility, subject to
304 federal approval, the agency and the department shall ensure
305 that each Medicaid recipient consents to the release of her or
306 his medical records to the agency and the Medicaid Fraud Control
307 Unit of the Department of Legal Affairs.

308 Section 5. Section 409.964, Florida Statutes is created to

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309 read:

310 409.964 Managed care program; state plan; waivers.—The
311 Medicaid program is established as a statewide, integrated
312 managed care program for all covered services, including long-
313 term care services. The agency shall apply for and implement
314 state plan amendments or waivers of applicable federal laws and
315 regulations necessary to implement the program. Before seeking a
316 waiver, the agency shall provide public notice and the
317 opportunity for public comment and include public feedback in
318 the waiver application. The agency shall hold one public meeting
319 in each of the regions described in s. 409.966(2) and the time
320 period for public comment for each region shall end no sooner
321 than 30 days after the completion of the public meeting in that
322 region. The agency shall submit any state plan amendments, new
323 waiver requests, or requests for extensions or expansions for
324 existing waivers, needed to implement the managed care program
325 by August 1, 2011.

326 Section 6. Section 409.965, Florida Statutes, is created
327 to read:

328 409.965 Mandatory enrollment.—All Medicaid recipients
329 shall receive covered services through the statewide managed
330 care program, except as provided by this part pursuant to an
331 approved federal waiver. The following Medicaid recipients are
332 exempt from participation in the statewide managed care program:

333 (1) Women who are eligible only for family planning
334 services.

335 (2) Women who are eligible only for breast and cervical
336 cancer services.

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337 (3) Persons who are eligible for emergency Medicaid for
338 aliens.

339 (4) Children receiving services in a prescribed pediatric
340 extended care center.

341 Section 7. Section 409.966, Florida Statutes, is created
342 to read:

343 409.966 Eligible plans; selection.—

344 (1) ELIGIBLE PLANS.—Services in the Medicaid managed care
345 program shall be provided by eligible plans. A provider service
346 network must be capable of providing all covered services to a
347 mandatory Medicaid managed care enrollee or may limit the
348 provision of services to a specific target population based on
349 the age, chronic disease state, or medical condition of the
350 enrollee to whom the network will provide services. A specialty
351 provider service network must be capable of coordinating care
352 and delivering or arranging for the delivery of all covered
353 services to the target population. A provider service network
354 may partner with an insurer licensed under chapter 627 or a
355 health maintenance organization licensed under chapter 641 to
356 meet the requirements of a Medicaid contract.

357 (2) ELIGIBLE PLAN SELECTION.—The agency shall select a
358 limited number of eligible plans to participate in the Medicaid
359 program using invitations to negotiate in accordance with s.
360 287.057(3)(a). At least 90 days before issuing an invitation to
361 negotiate, the agency shall compile and publish a databook
362 consisting of a comprehensive set of utilization and spending
363 data for the 3 most recent contract years consistent with the
364 rate-setting periods for all Medicaid recipients by region or

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365 county. The source of the data in the report must include both
366 historic fee-for-service claims and validated data from the
367 Medicaid Encounter Data System. The report must be available in
368 electronic form and delineate utilization use by age, gender,
369 eligibility group, geographic area, and aggregate clinical risk
370 score. Separate and simultaneous procurements shall be conducted
371 in each of the following regions:

372 (a) Region 1, which consists of Escambia, Okaloosa, Santa
373 Rosa and Walton Counties.

374 (b) Region 2, which consists of Bay, Calhoun, Franklin,
375 Gadsden, Gulf, Holmes, Jackson, Jefferson, Leon, Liberty,
376 Madison, Taylor, Wakulla, and Washington Counties.

377 (c) Region 3, which consists of Alachua, Bradford, Citrus,
378 Columbia, Dixie, Gilchrist, Hamilton, Hernando, Lafayette, Lake,
379 Levy, Marion, Putnam, Sumter, Suwannee, and Union Counties.

380 (d) Region 4, which consists of Baker, Clay, Duval,
381 Flagler, Nassau, St. Johns, and Volusia Counties.

382 (e) Region 5, which consists of Pasco and Pinellas
383 Counties.

384 (f) Region 6, which consists of Hardee, Highlands,
385 Hillsborough, Manatee and Polk Counties.

386 (g) Region 7, which consists of Brevard, Orange, Osceola
387 and Seminole Counties.

388 (h) Region 8, which consists of Charlotte, Collier,
389 DeSoto, Glades, Hendry, Lee, and Sarasota Counties.

390 (i) Region 9, which consists of Indian River, Martin,
391 Okeechobee, Palm Beach and St. Lucie Counties.

392 (j) Region 10, which consists of Broward County.

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393 (k) Region 11, which consists of Miami-Dade and Monroe
394 Counties.

395 (3) QUALITY SELECTION CRITERIA.—

396 (a) The invitation to negotiate must specify the criteria
397 and the relative weight of the criteria that will be used for
398 determining the acceptability of the reply and guiding the
399 selection of the organizations with which the agency negotiates.
400 In addition to criteria established by the agency, the agency
401 shall consider the following factors in the selection of
402 eligible plans:

403 1. Accreditation by the National Committee for Quality
404 Assurance, the Joint Commission, or another nationally
405 recognized accrediting body.

406 2. Experience serving similar populations, including the
407 organization's record in achieving specific quality standards
408 with similar populations.

409 3. Availability and accessibility of primary care and
410 specialty physicians in the provider network.

411 4. Establishment of community partnerships with providers
412 that create opportunities for reinvestment in community-based
413 services.

414 5. Organization commitment to quality improvement and
415 documentation of achievements in specific quality improvement
416 projects, including active involvement by organization
417 leadership.

418 6. Provision of additional benefits, particularly dental
419 care and disease management, and other initiatives that improve
420 health outcomes.

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421 7. Evidence that a eligible plan has written agreements or
422 signed contracts or has made substantial progress in
423 establishing relationships with providers before the plan
424 submitting a response.

425 8. Comments submitted in writing by any enrolled Medicaid
426 provider relating to a specifically identified plan
427 participating in the procurement in the same region as the
428 submitting provider.

429 9. Documentation of policies and procedures for preventing
430 fraud and abuse.

431 10. The business relationship an eligible plan has with
432 any other eligible plan that responds to the invitation to
433 negotiate.

434 (b) An eligible plan must disclose any business
435 relationship it has with any other eligible plan that responds to
436 the invitation to negotiate. The agency may not select plans in
437 the same region for the same managed care program that have a
438 business relationship with each other. Failure to disclose any
439 business relationship shall result in disqualification from
440 participation in any region for the first full contract period
441 after the discovery of the business relationship by the agency.
442 For the purpose of this section, "business relationship" means
443 an ownership or controlling interest, an affiliate or subsidiary
444 relationship, a common parent, or any mutual interest in any
445 limited partnership, limited liability partnership, limited
446 liability company, or other entity or business association,
447 including all wholly or partially owned subsidiaries, majority-
448 owned subsidiaries, parent companies, or affiliates of such

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449 entities, business associations, or other enterprises, that
450 exists for the purpose of making a profit.

451 (c) After negotiations are conducted, the agency shall
452 select the eligible plans that are determined to be responsive
453 and provide the best value to the state. Preference shall be
454 given to plans that:

455 1. Have signed contracts with primary and specialty
456 physicians in sufficient numbers to meet the specific standards
457 established pursuant to s. 409.967(2)(b).

458 2. Have well-defined programs for recognizing patient-
459 centered medical homes and providing for increased compensation
460 for recognized medical homes, as defined by the plan.

461 3. Are organizations that are based in and perform
462 operational functions in this state, in-house or through
463 contractual arrangements, by staff located in this state. Using
464 a tiered approach, the highest number of points shall be awarded
465 to a plan that has all or substantially all of its operational
466 functions performed in the state. The second highest number of
467 points shall be awarded to a plan that has a majority of its
468 operational functions performed in the state. The agency may
469 establish a third tier; however, preference points may not be
470 awarded to plans that perform only community outreach, medical
471 director functions, and state administrative functions in the
472 state. For purposes of this subparagraph, operational functions
473 include claims processing, member services, provider relations,
474 utilization and prior authorization, case management, disease
475 and quality functions, and finance and administration. For
476 purposes of this subparagraph, the term "based in this state"

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means that the entity's principal office is in this state and the plan is not a subsidiary, directly or indirectly through one or more subsidiaries of, or a joint venture with, any other entity whose principal office is not located in the state.

4. Have contracts or other arrangements for cancer disease management programs that have a proven record of clinical efficiencies and cost savings.

5. Have contracts or other arrangements for diabetes disease management programs that have a proven record of clinical efficiencies and cost savings.

6. Have a claims payment process that ensures that claims that are not contested or denied will be promptly paid pursuant to s. 641.3155.

(d) For the first year of the first contract term, the agency shall negotiate capitation rates or fee for service payments with each plan in order to guarantee aggregate savings of at least 5 percent.

1. For prepaid plans, determination of the amount of savings shall be calculated by comparison to the Medicaid rates that the agency paid managed care plans for similar populations in the same areas in the prior year. In regions containing no prepaid plans in the prior year, determination of the amount of savings shall be calculated by comparison to the Medicaid rates established and certified for those regions in the prior year.

2. For provider service networks operating on a fee-for-service basis, determination of the amount of savings shall be calculated by comparison to the Medicaid rates that the agency paid on a fee-for-service basis for the same services in the

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505 prior year.

506 (e) To ensure managed care plan participation in Regions 1
507 and 2, the agency shall award an additional contract to each
508 plan with a contract award in Region 1 or Region 2. Such
509 contract shall be in any other region in which the plan
510 submitted a responsive bid and negotiates a rate acceptable to
511 the agency. If a plan that is awarded an additional contract
512 pursuant to this paragraph is subject to penalties pursuant to
513 s. 409.967(2)(g) for activities in Region 1 or Region 2, the
514 additional contract is automatically terminated 180 days after
515 the imposition of the penalties. The plan must reimburse the
516 agency for the cost of enrollment changes and other transition
517 activities.

518 (f) The agency may not execute contracts with managed care
519 plans at payment rates not supported by the General
520 Appropriations Act.

521 (4) ADMINISTRATIVE CHALLENGE.—Any eligible plan that
522 participates in an invitation to negotiate in more than one
523 region and is selected in at least one region may not begin
524 serving Medicaid recipients in any region for which it was
525 selected until all administrative challenges to procurements
526 required by this section to which the eligible plan is a party
527 have been finalized. If the number of plans selected is less
528 than the maximum amount of plans permitted in the region, the
529 agency may contract with other selected plans in the region not
530 participating in the administrative challenge before resolution
531 of the administrative challenge. For purposes of this
532 subsection, an administrative challenge is finalized if an order

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533 granting voluntary dismissal with prejudice has been entered by
534 any court established under Article V of the State Constitution
535 or by the Division of Administrative Hearings, a final order has
536 been entered into by the agency and the deadline for appeal has
537 expired, a final order has been entered by the First District
538 Court of Appeal and the time to seek any available review by the
539 Florida Supreme Court has expired, or a final order has been
540 entered by the Florida Supreme Court and a warrant has been
541 issued.

542 Section 8. Section 409.967, Florida Statutes, is created
543 to read:

544 409.967 Managed care plan accountability.—

545 (1) The agency shall establish a 5-year contract with each
546 managed care plan selected through the procurement process
547 described in s. 409.966. A plan contract may not be renewed;
548 however, the agency may extend the term of a plan contract to
549 cover any delays during the transition to a new plan.

550 (2) The agency shall establish such contract requirements
551 as are necessary for the operation of the statewide managed care
552 program. In addition to any other provisions the agency may deem
553 necessary, the contract must require:

554 (a) Physician compensation.—Managed care plans are
555 expected to coordinate care, manage chronic disease, and prevent
556 the need for more costly services. Effective care management
557 should enable plans to redirect available resources and increase
558 compensation for physicians. Plans achieve this performance
559 standard when physician payment rates equal or exceed Medicare
560 rates for similar services. The agency may impose fines or

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561 other sanctions on a plan that fails to meet this performance
562 standard after 2 years of continuous operation.

563 (b) Emergency services.—Managed care plans shall pay for
564 services required by ss. 395.1041 and 401.45 and rendered by a
565 noncontracted provider. The plans must comply with s. 641.3155.
566 Reimbursement for services under this paragraph is the lesser
567 of:

- 568 1. The provider's charges;
- 569 2. The usual and customary provider charges for similar
570 services in the community where the services were provided;
- 571 3. The charge mutually agreed to by the entity and the
572 provider within 60 days after submittal of the claim; or
- 573 4. The rate the agency would have paid on the most recent
574 October 1st.

575 (c) Access.—

- 576 1. The agency shall establish specific standards for the
577 number, type, and regional distribution of providers in managed
578 care plan networks to ensure access to care for both adults and
579 children. Each plan must maintain a region-wide network of
580 providers in sufficient numbers to meet the access standards for
581 specific medical services for all recipients enrolled in the
582 plan. The exclusive use of mail-order pharmacies may not be
583 sufficient to meet network access standards. Consistent with the
584 standards established by the agency, provider networks may
585 include providers located outside the region. A plan may
586 contract with a new hospital facility before the date the
587 hospital becomes operational if the hospital has commenced
588 construction, will be licensed and operational by January 1,

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2013, and a final order has issued in any civil or administrative challenge. Each plan shall establish and maintain an accurate and complete electronic database of contracted providers, including information about licensure or registration, locations and hours of operation, specialty credentials and other certifications, specific performance indicators, and such other information as the agency deems necessary. The database must be available online to both the agency and the public and have the capability to compare the availability of providers to network adequacy standards and to accept and display feedback from each provider's patients. Each plan shall submit quarterly reports to the agency identifying the number of enrollees assigned to each primary care provider.

2. Each managed care plan must publish any prescribed drug formulary or preferred drug list on the plan's website in a manner that is accessible to and searchable by enrollees and providers. The plan must update the list within 24 hours after making a change. Each plan must ensure that the prior authorization process for prescribed drugs is readily accessible to health care providers, including posting appropriate contact information on its website and providing timely responses to providers. For Medicaid recipients diagnosed with hemophilia who have been prescribed anti-hemophilic-factor replacement products, the agency shall provide for those products and hemophilia overlay services through the agency's hemophilia disease management program.

3. Managed care plans, and their fiscal agents or intermediaries, must accept prior authorization requests for any

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617 service electronically.

618 (d) Encounter data.—The agency shall maintain and operate
619 a Medicaid Encounter Data System to collect, process, store, and
620 report on covered services provided to all Medicaid recipients
621 enrolled in prepaid plans.

622 1. Each prepaid plan must comply with the agency's
623 reporting requirements for the Medicaid Encounter Data System.
624 Prepaid plans must submit encounter data electronically in a
625 format that complies with the Health Insurance Portability and
626 Accountability Act provisions for electronic claims and in
627 accordance with deadlines established by the agency. Prepaid
628 plans must certify that the data reported is accurate and
629 complete.

630 2. The agency is responsible for validating the data
631 submitted by the plans. The agency shall develop methods and
632 protocols for ongoing analysis of the encounter data that
633 adjusts for differences in characteristics of prepaid plan
634 enrollees to allow comparison of service utilization among plans
635 and against expected levels of use. The analysis shall be used
636 to identify possible cases of systemic underutilization or
637 denials of claims and inappropriate service utilization such as
638 higher-than-expected emergency department encounters. The
639 analysis shall provide periodic feedback to the plans and enable
640 the agency to establish corrective action plans when necessary.
641 One of the focus areas for the analysis shall be the use of
642 prescription drugs.

643 3. The agency shall make encounter data available to those
644 plans accepting enrollees who are assigned to them from other

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645 plans leaving a region.

646 (e) Continuous improvement.—The agency shall establish
647 specific performance standards and expected milestones or
648 timelines for improving performance over the term of the
649 contract.

650 1. Each managed care plan shall establish an internal
651 health care quality improvement system, including enrollee
652 satisfaction and disenrollment surveys. The quality improvement
653 system must include incentives and disincentives for network
654 providers.

655 2. Each plan must collect and report the Health Plan
656 Employer Data and Information Set (HEDIS) measures, as specified
657 by the agency. These measures must be published on the plan's
658 website in a manner that allows recipients to reliably compare
659 the performance of plans. The agency shall use the HEDIS
660 measures as a tool to monitor plan performance.

661 3. Each managed care plan must be accredited by the
662 National Committee for Quality Assurance, the Joint Commission,
663 or another nationally recognized accrediting body, or have
664 initiated the accreditation process, within 1 year after the
665 contract is executed. For any plan not accredited within 18
666 months after executing the contract, the agency shall suspend
667 automatic assignment under s. 409.977 and 409.984.

668 4. By the end of the fourth year of the first contract
669 term, the agency shall issue a request for information to
670 determine whether cost savings could be achieved by contracting
671 for plan oversight and monitoring, including analysis of
672 encounter data, assessment of performance measures, and

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673 compliance with other contractual requirements.

674 (f) Program integrity.—Each managed care plan shall
675 establish program integrity functions and activities to reduce
676 the incidence of fraud and abuse, including, at a minimum:

677 1. A provider credentialing system and ongoing provider
678 monitoring, including maintenance of written provider
679 credentialing policies and procedures which comply with federal
680 and agency guidelines;

681 2. An effective prepayment and postpayment review process
682 including, but not limited to, data analysis, system editing,
683 and auditing of network providers;

684 3. Procedures for reporting instances of fraud and abuse
685 pursuant to chapter 641;

686 4. Administrative and management arrangements or
687 procedures, including a mandatory compliance plan, designed to
688 prevent fraud and abuse; and

689 5. Designation of a program integrity compliance officer.

690 (g) Grievance resolution.—Consistent with federal law,
691 each managed care plan shall establish and the agency shall
692 approve an internal process for reviewing and responding to
693 grievances from enrollees. Each plan shall submit quarterly
694 reports on the number, description, and outcome of grievances
695 filed by enrollees.

696 (h) Penalties.—

697 1. Withdrawal and enrollment reduction.—Managed care plans
698 that reduce enrollment levels or leave a region before the end
699 of the contract term must reimburse the agency for the cost of
700 enrollment changes and other transition activities. If more than

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one plan leaves a region at the same time, costs must be shared by the departing plans proportionate to their enrollments. In addition to the payment of costs, departing provider services networks must pay a per enrollee penalty of up to 3 month's payment and continue to provide services to the enrollee for 90 days or until the enrollee is enrolled in another plan, whichever occurs first. In addition to payment of costs, all other plans must pay a penalty of 25 percent of the minimum surplus requirement pursuant to s. 641.225(1). Plans shall provide at least 180 days notice to the agency before withdrawing from a region. If a managed care plan leaves a region before the end of the contract term, the agency shall terminate all contracts with that plan in other regions, pursuant to the termination procedures in subparagraph 3.

2. Encounter data.—If a plan fails to comply with the encounter data reporting requirements of this section for 30 days, the agency must assess a fine of \$5,000 per day for each day of noncompliance beginning on the 31st day. On the 31st day, the agency must notify the plan that the agency will initiate contract termination procedures on the 90th day unless the plan comes into compliance before that date.

3. Termination.—If the agency terminates more than one regional contract with the same managed care plan due to noncompliance with the requirements of this section, the agency shall terminate all the regional contracts held by that plan. When terminating multiple contracts, the agency must develop a plan to transition enrollees to other plans, and phase-in the terminations over a time period sufficient to ensure a smooth

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transition.

(i) Prompt payment.—Managed care plans shall comply with ss. 641.315, 641.3155, and 641.513.

(j) Electronic claims.—Managed care plans, and their fiscal agents or intermediaries, shall accept electronic claims in compliance with federal standards.

(k) Fair payment.—Provider service networks must ensure that no entity licensed under chapter 395 with a controlling interest in the network charges a Medicaid managed care plan more than the amount paid to that provider by the provider service network for the same service.

(l) Itemized payment.—Any claims payment to a provider by a managed care plan, or by a fiscal agent or intermediary of the plan, must be accompanied by an itemized accounting of the individual claims included in the payment including, but not limited to, the enrollee's name, the date of service, the procedure code, the amount of reimbursement, and the identification of the plan on whose behalf the payment is made.

(m) Provider dispute resolution.—Disputes between a plan and a provider may be resolved as described in s. 408.7057.

(3) ACHIEVED SAVINGS REBATE.—

(a) The agency is responsible for verifying the achieved savings rebate for all Medicaid prepaid plans. To assist the agency, a prepaid plan shall:

1. Submit an annual financial audit conducted by an independent certified public accountant in accordance with generally accepted auditing standards to the agency on or before June 1 for the preceding year; and

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2. Submit an annual statement prepared in accordance with statutory accounting principles on or before March 1 pursuant to s. 624.424 if the plan is regulated by the Office of Insurance Regulation.

(b) The agency shall contract with independent certified public accountants to conduct compliance audits for the purpose of auditing financial information, including but not limited to: annual premium revenue, medical and administrative costs, and income or losses reported by each prepaid plan, in order to determine and validate the achieved savings rebate.

(c) Any audit required under this subsection must be conducted by an independent certified public accountant who meets criteria specified by rule. The rules must also provide that:

1. The entity selected by the agency to conduct the audit may not have a conflict of interest that might affect its ability to perform its responsibilities with respect to an examination.

2. The rates charged to the prepaid plan being audited are consistent with rates charged by other certified public accountants and are comparable with the rates charged for comparable examinations.

3. Each prepaid plan audited shall pay to the agency the expenses of the audit at the rates established by the agency by rule. Such expenses include actual travel expenses, reasonable living expense allowances, compensation of the certified public accountant, and necessary attendant administrative costs of the agency directly related to the examination. Travel expense and

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785 living expense allowances are limited to those expenses incurred
786 on account of the audit and must be paid by the examined prepaid
787 plan together with compensation upon presentation by the agency
788 to the prepaid plan of a detailed account of the charges and
789 expenses after a detailed statement has been filed by the
790 auditor and approved by the agency.

791 4. All moneys collected from prepaid plans for such audits
792 shall be deposited into the Grants and Donations Trust Fund and
793 the agency may make deposits into such fund from moneys
794 appropriated for the operation of the agency.

795 (d) At a location in this state, the prepaid plan shall
796 make available to the agency and the agency's contracted
797 certified public accountant all books, accounts, documents,
798 files, information, that relate to the prepaid plan's Medicaid
799 transactions. Records not in the prepaid plan's immediate
800 possession must be made available to the agency or the certified
801 public accountant in this state within 3 days after a request is
802 made by the agency or certified public accountant engaged by the
803 agency. A prepaid plan has an obligation to cooperate in good
804 faith with the agency and the certified public accountant.
805 Failure to comply to such record requests shall be deemed a
806 breach of contract.

807 (e) Once the certified public accountant completes the
808 audit, the certified public accountant shall submit an audit
809 report to the agency attesting to the achieved savings of the
810 plan. The results of the audit report are dispositive.

811 (f) Achieved savings rebates validated by the certified
812 public accountant are due within 30 days after the report is

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submitted. Except as provided in paragraph (h), the achieved savings rebate is established by determining pretax income as a percentage of revenues and applying the following income sharing ratios:

1. One hundred percent of income up to and including 5 percent of revenue shall be retained by the plan.

2. Fifty percent of income above 5 percent and up to 10 percent shall be retained by the plan, and the other 50 percent refunded to the state.

3. One hundred percent of income above 10 percent of revenue shall be refunded to the state.

(g) A plan that exceeds agency-defined quality measures in the reporting period may retain an additional 1 percent of revenue. For the purpose of this paragraph, the quality measures must include plan performance for preventing or managing complex, chronic conditions that are associated with an elevated likelihood of requiring high-cost medical treatments.

(h) The following may not be included as allowable expenses in calculating income for determining the achieved savings rebate:

1. Payment of achieved savings rebates.

2. Any financial incentive payments made to the plan outside of the capitation rate.

3. Any financial disincentive payments levied by the state or federal governments.

4. Expenses associated with any lobbying or political activities.

5. The cash value or equivalent cash value of bonuses of

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any type paid or awarded to the plan's executive staff, other than base salary.

6. Reserves and reserve accounts.

7. Administrative costs, including, but not limited to, reinsurance expenses, interest payments, depreciation expenses, bad debt expenses, and outstanding claims expenses in excess of actuarially sound maximum amounts set by the agency.

The agency shall consider these and other factors in developing contracts that establish shared savings arrangements.

(i) Prepaid plans that incur a loss in the first contract year may apply the full amount of the loss as an offset to income in the second contract year.

(j) If, after an audit, the agency determines that a prepaid plan owes an additional rebate, the plan has 30 days after notification to make the payment. Upon failure to timely pay the rebate, the agency shall withhold future payments to the plan until the entire amount is recouped. If the agency determines that a prepaid plan has made an overpayment, the agency shall return the overpayment within 30 days.

Section 9. Section 409.968, Florida Statutes, is created to read:

409.968 Managed care plan payments.—

(1) Prepaid plans shall receive per-member, per-month payments negotiated pursuant to the procurements described in s. 409.966. Payments shall be risk-adjusted rates based on historical utilization and spending data, projected forward, and adjusted to reflect the eligibility category, geographic area,

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869 and clinical risk profile of the recipients. In negotiating
870 rates with the plans, the agency shall consider any adjustments
871 necessary to encourage plans to use the most cost effective
872 modalities for treatment of chronic disease such as peritoneal
873 dialysis.

874 (2) Provider service networks may be prepaid plans and
875 receive per-member, per-month payments negotiated pursuant to
876 the procurement process described in s. 409.966. Provider
877 service networks that choose not to be prepaid plans shall
878 receive fee-for-service rates with a shared savings settlement.
879 The fee-for-service option shall be available to a provider
880 service network only for the first 2 years of its operation. The
881 agency shall annually conduct cost reconciliations to determine
882 the amount of cost savings achieved by fee-for-service provider
883 service networks for the dates of service within the period
884 being reconciled. Only payments for covered services for dates
885 of service within the reconciliation period and paid within 6
886 months after the last date of service in the reconciliation
887 period must be included. The agency shall perform the necessary
888 adjustments for the inclusion of claims incurred but not
889 reported within the reconciliation period for claims that could
890 be received and paid by the agency after the 6-month claims
891 processing time lag. The agency shall provide the results of the
892 reconciliations to the fee-for-service provider service networks
893 within 45 days after the end of the reconciliation period. The
894 fee-for-service provider service networks shall review and
895 provide written comments or a letter of concurrence to the
896 agency within 45 days after receipt of the reconciliation

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897 results. This reconciliation is considered final.

898 (3) The agency may not approve any plan request for a rate
899 increase unless sufficient funds to support the increase have
900 been authorized in the General Appropriations Act.

901 Section 10. Section 409.969, Florida Statutes, is created
902 to read:

903 409.969 Enrollment; disenrollment.—

904 (1) ENROLLMENT.—All Medicaid recipients shall be enrolled
905 in a managed care plan unless specifically exempted under this
906 part. Each recipient shall have a choice of plans and may select
907 any available plan unless that plan is restricted by contract to
908 a specific population that does not include the recipient.
909 Medicaid recipients shall have 30 days in which to make a choice
910 of plans.

911 (2) DISENROLLMENT; GRIEVANCES.—After a recipient has
912 enrolled in a managed care plan, the recipient shall have 90
913 days to voluntarily disenroll and select another plan. After 90
914 days, no further changes may be made except for good cause. For
915 purposes of this section, the term "good cause" includes, but is
916 not limited to, poor quality of care, lack of access to
917 necessary specialty services, an unreasonable delay or denial of
918 service, or fraudulent enrollment. The agency must make a
919 determination as to whether good cause exists. The agency may
920 require a recipient to use the plan's grievance process before
921 the agency's determination of good cause, except in cases in
922 which immediate risk of permanent damage to the recipient's
923 health is alleged.

924 (a) The managed care plan internal grievance process, when

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925 used, must be completed in time to permit the recipient to
926 disenroll by the first day of the second month after the month
927 the disenrollment request was made. If the result of the
928 grievance process is approval of an enrollee's request to
929 disenroll, the agency is not required to make a determination in
930 the case.

931 (b) The agency must make a determination and take final
932 action on a recipient's request so that disenrollment occurs no
933 later than the first day of the second month after the month the
934 request was made. If the agency fails to act within the
935 specified timeframe, the recipient's request to disenroll is
936 deemed to be approved as of the date agency action was required.
937 Recipients who disagree with the agency's finding that good
938 cause does not exist for disenrollment shall be advised of their
939 right to pursue a Medicaid fair hearing to dispute the agency's
940 finding.

941 (c) Medicaid recipients enrolled in a managed care plan
942 after the 90-day period shall remain in the plan for the
943 remainder of the 12-month period. After 12 months, the recipient
944 may select another plan. However, nothing shall prevent a
945 Medicaid recipient from changing providers within the plan
946 during that period.

947 (d) On the first day of the month after receiving notice
948 from a recipient that the recipient has moved to another region,
949 the agency shall automatically disenroll the recipient from the
950 managed care plan the recipient is currently enrolled in and
951 treat the recipient as if the recipient is a new Medicaid
952 enrollee. At that time, the recipient may choose another plan

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pursuant to the enrollment process established in this section.

(e) The agency must monitor plan disenrollment throughout the contract term to identify any discriminatory practices.

Section 11. Section 409.97, Florida Statutes, is created to read:

409.97 State and local Medicaid partnerships.—

(1) INTERGOVERNMENTAL TRANSFERS.—In addition to the contributions required pursuant to s. 409.915, beginning in the 2014-2015 fiscal year, the agency may accept voluntary transfers of local taxes and other qualified revenue from counties, municipalities, and special taxing districts. Such transfers must be contributed to advance the general goals of the Florida Medicaid program without restriction and must be executed pursuant to a contract between the agency and the local funding source. Contracts executed before October 31 shall result in contributions to Medicaid for that same state fiscal year. Contracts executed between November 1 and June 30 shall result in contributions for the following state fiscal year. Based on the date of the signed contracts, the agency shall allocate to the low-income pool the first contributions received up to the limit established by subsection (2). No more than 40 percent of the low-income pool funding shall come from any single funding source. Contributions in excess of the low-income pool shall be allocated to the disproportionate share programs defined in ss. 409.911(3) and 409.9113 and to hospital rates pursuant to subsection (4). The local funding source shall designate in the contract which Medicaid providers ensure access to care for low-income and uninsured people within the applicable jurisdiction

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981 and are eligible for low-income pool funding. Eligible providers
982 may include hospitals, primary care providers, and primary care
983 access systems.

984 (2) LOW-INCOME POOL.—The agency shall establish and
985 maintain a low-income pool in a manner authorized by federal
986 waiver. The low-income pool is created to compensate a network
987 of providers designated pursuant to subsection (1). Funding of
988 the low-income pool shall be limited to the maximum amount
989 permitted by federal waiver minus a percentage specified in the
990 General Appropriations Act. The low-income pool must be used to
991 support enhanced access to services by offsetting shortfalls in
992 Medicaid reimbursement, paying for otherwise uncompensated care,
993 and financing coverage for the uninsured. The low-income pool
994 shall be distributed in periodic payments to the Access to Care
995 Partnership throughout the fiscal year. Distribution of low-
996 income pool funds by the Access to Care Partnership to
997 participating providers may be made through capitated payments,
998 fees for services, or contracts for specific deliverables. The
999 agency shall include the distribution amount for each provider
1000 in the contract with the Access to Care Partnership pursuant to
1001 subsection (3). Regardless of the method of distribution,
1002 providers participating in the Access to Care Partnership shall
1003 receive payments such that the aggregate benefit in the
1004 jurisdiction of each local funding source, as defined in
1005 subsection (1), equals the amount of the contribution plus a
1006 factor specified in the General Appropriations Act.

1007 (3) ACCESS TO CARE PARTNERSHIP.—The agency shall contract
1008 with an administrative services organization that has operating

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1009 agreements with all health care facilities, programs, and
1010 providers supported with local taxes or certified public
1011 expenditures and designated pursuant to subsection (1). The
1012 contract shall provide for enhanced access to care for Medicaid,
1013 low-income, and uninsured Floridians. The partnership shall be
1014 responsible for an ongoing program of activities that provides
1015 needed, but uncovered or undercompensated, health services to
1016 Medicaid enrollees and persons receiving charity care, as
1017 defined in s. 409.911. Accountability for services rendered
1018 under this contract must be based on the number of services
1019 provided to unduplicated qualified beneficiaries, the total
1020 units of service provided to these persons, and the
1021 effectiveness of services provided as measured by specific
1022 standards of care. The agency shall seek such plan amendments or
1023 waivers as may be necessary to authorize the implementation of
1024 the low-income pool as the Access to Care Partnership pursuant
1025 to this section.

1026 (4) HOSPITAL RATE DISTRIBUTION.—

1027 (a) The agency is authorized to implement a tiered
1028 hospital rate system to enhance Medicaid payments to all
1029 hospitals when resources for the tiered rates are available from
1030 general revenue and such contributions pursuant to subsection
1031 (1) as are authorized under the General Appropriations Act.

1032 1. Tier 1 hospitals are statutory rural hospitals as
1033 defined in s. 395.602, statutory teaching hospitals as defined
1034 in s. 408.07(45), and specialty children's hospitals as defined
1035 in s. 395.002(28).

1036 2. Tier 2 hospitals are community hospitals not included

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in Tier 1 that provided more than 9 percent of the hospital's total inpatient days to Medicaid patients and charity patients, as defined in s. 409.911, and are located in the jurisdiction of a local funding source pursuant to subsection (1).

3. Tier 3 hospitals include all community hospitals.

(b) When rates are increased pursuant to this section, the Total Tier Allocation (TTA) shall be distributed as follows:

1. Tier 1 (T1A) = 0.35 x TTA.

2. Tier 2 (T2A) = 0.35 x TTA.

3. Tier 3 (T3A) = 0.30 x TTA.

(c) The tier allocation shall be distributed as a percentage increase to the hospital specific base rate (HSBR) established pursuant to s. 409.905(5)(c). The increase in each tier shall be calculated according to the proportion of tier-specific allocation to the total estimated inpatient spending (TEIS) for all hospitals in each tier:

1. Tier 1 percent increase (T1PI) = T1A/Tier 1 total estimated inpatient spending (T1TEIS).

2. Tier 2 percent increase (T2PI) = T2A /Tier 2 total estimated inpatient spending (T2TEIS).

3. Tier 3 percent increase (T3PI) = T3A/ Tier 3 total estimated inpatient spending (T3TEIS).

(d) The hospital-specific tiered rate (HSTR) shall be calculated as follows:

1. For hospitals in Tier 3: HSTR = (1 + T3PI) x HSBR.

2. For hospitals in Tier 2: HSTR = (1 + T2PI) x HSBR.

3. For hospitals in Tier 1: HSTR = (1 + T1PI) x HSBR.

Section 12. Section 409.971, Florida Statutes, is created

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to read:

409.971 Managed medical assistance program.—The agency shall make payments for primary and acute medical assistance and related services using a managed care model. By January 1, 2013, the agency shall begin implementation of the statewide managed medical assistance program, with full implementation in all regions by October 1, 2014.

Section 13. Section 409.972, Florida Statutes, is created to read:

409.972 Mandatory and voluntary enrollment.—

(1) Persons eligible for the program known as "medically needy" pursuant to s. 409.904(2)(a) shall enroll in managed care plans. Medically needy recipients shall meet the share of the cost by paying the plan premium, up to the share of the cost amount, contingent upon federal approval.

(2) The following Medicaid-eligible persons are exempt from mandatory managed care enrollment required by s. 409.965, and may voluntarily choose to participate in the managed medical assistance program:

(a) Medicaid recipients who have other creditable health care coverage, excluding Medicare.

(b) Medicaid recipients residing in residential commitment facilities operated through the Department of Juvenile Justice or mental health treatment facilities as defined by s. 394.455(32).

(c) Persons eligible for refugee assistance.

(d) Medicaid recipients who are residents of a developmental disability center, including Sunland Center in

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1093 Marianna and Tacachale in Gainesville.

1094 (e) Medicaid recipients enrolled in the home and community
1095 based services waiver pursuant to chapter 393, and Medicaid
1096 recipients waiting for waiver services.

1097 (3) Persons eligible for Medicaid but exempt from
1098 mandatory participation who do not choose to enroll in managed
1099 care shall be served in the Medicaid fee-for-service program as
1100 provided in part III of this chapter.

1101 (4) The agency shall seek federal approval to require
1102 Medicaid recipients enrolled in managed care plans, as a
1103 condition of Medicaid eligibility, to pay the Medicaid program a
1104 share of the premium of \$10 per month.

1105 Section 14. Section 409.973, Florida Statutes, is created
1106 to read:

1107 409.973 Benefits.—

1108 (1) MINIMUM BENEFITS.—Managed care plans shall cover, at a
1109 minimum, the following services:

1110 (a) Advanced registered nurse practitioner services.

1111 (b) Ambulatory surgical treatment center services.

1112 (c) Birthing center services.

1113 (d) Chiropractic services.

1114 (e) Dental services.

1115 (f) Early periodic screening diagnosis and treatment
1116 services for recipients under age 21.

1117 (g) Emergency services.

1118 (h) Family planning services and supplies. Pursuant to 42
1119 C.F.R. s. 438.102, plans may elect to not provide these services
1120 due to an objection on moral or religious grounds, and must

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notify the agency of that election when submitting a reply to an invitation to negotiate.

(i) Healthy start services, except as provided in s. 409.975(4).

(j) Hearing services.

(k) Home health agency services.

(l) Hospice services.

(m) Hospital inpatient services.

(n) Hospital outpatient services.

(o) Laboratory and imaging services.

(p) Medical supplies, equipment, prostheses, and orthoses.

(q) Mental health services.

(r) Nursing care.

(s) Optical services and supplies.

(t) Optometrist services.

(u) Physical, occupational, respiratory, and speech therapy services.

(v) Physician services, including physician assistant services.

(w) Podiatric services.

(x) Prescription drugs.

(y) Renal dialysis services.

(z) Respiratory equipment and supplies.

(aa) Rural health clinic services.

(bb) Substance abuse treatment services.

(cc) Transportation to access covered services.

(2) CUSTOMIZED BENEFITS.—Managed care plans may customize benefit packages for nonpregnant adults, vary cost-sharing

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1149 provisions, and provide coverage for additional services. The
1150 agency shall evaluate the proposed benefit packages to ensure
1151 services are sufficient to meet the needs of the plan's
1152 enrollees and to verify actuarial equivalence.

1153 (3) HEALTHY BEHAVIORS.—Each plan operating in the managed
1154 medical assistance program shall establish a program to
1155 encourage and reward healthy behaviors. At a minimum, each plan
1156 must establish a medically approved smoking cessation program, a
1157 medically directed weight loss program, and a medically approved
1158 alcohol or substance abuse recovery program. Each plan must
1159 identify enrollees who smoke, are morbidly obese, or are
1160 diagnosed with alcohol or substance abuse in order to establish
1161 written agreements to secure the enrollees' commitment to
1162 participation in these programs.

1163 (4) PRIMARY CARE INITIATIVE.—Each plan operating in the
1164 managed medical assistance program shall establish a program to
1165 encourage enrollees to establish a relationship with their
1166 primary care provider. Each plan shall:

1167 (a) Provide information to each enrollee on the importance
1168 of and procedure for selecting a primary care physician, and
1169 thereafter automatically assign to a primary care provider any
1170 enrollee who fails to choose a primary care provider.

1171 (b) If the enrollee was not a Medicaid recipient before
1172 enrollment in the plan, assist the enrollee in scheduling an
1173 appointment with the primary care provider. If possible the
1174 appointment should be made within 30 days after enrollment in
1175 the plan. For enrollees who become eligible for Medicaid between
1176 January 1, 2014, and December 31, 2015, the appointment should

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be be scheduled within 6 months after enrollment in the plan.

(c) Report to the agency the number of enrollees assigned to each primary care provider within the plan's network.

(d) Report to the agency the number of enrollees who have not had an appointment with their primary care provider within their first year of enrollment.

(e) Report to the agency the number of emergency room visits by enrollees who have not had a least one appointment with their primary care provider.

Section 15. Section 409.974, Florida Statutes, is created to read:

409.974 Eligible plans.—

(1) ELIGIBLE PLAN SELECTION.—The agency shall select eligible plans through the procurement process described in s. 409.966. The agency shall notice invitations to negotiate no later than January 1, 2013.

(a) The agency shall procure two plans for Region 1. At least one plan shall be a provider service network if any provider service networks submit a responsive bid.

(b) The agency shall procure two plans for Region 2. At least one plan shall be a provider service network if any provider service networks submit a responsive bid.

(c) The agency shall procure at least three plans and up to five plans for Region 3. At least one plan must be a provider service network if any provider service networks submit a responsive bids.

(d) The agency shall procure at least three plans and up to five plans for Region 4. At least one plan must be a provider

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1205 service network if any provider service networks submit a
1206 responsive bid.

1207 (e) The agency shall procure at least two plans and up to
1208 4 plans for Region 5. At least one plan must be a provider
1209 service network if any provider service networks submit a
1210 responsive bid.

1211 (f) The agency shall procure at least four plans and up to
1212 seven plans for Region 6. At least one plan must be a provider
1213 service network if any provider service networks submit a
1214 responsive bid.

1215 (g) The agency shall procure at least three plans and up
1216 to six plans for Region 7. At least one plan must be a provider
1217 service network if any provider service networks submit a
1218 responsive bid.

1219 (h) The agency shall procure at least two plans and up to
1220 four plans for Region 8. At least one plan must be a provider
1221 service network if any provider service networks submit a
1222 responsive bid.

1223 (i) The agency shall procure at least two plans and up to
1224 four plans for Region 9. At least one plan must be a provider
1225 service network if any provider service networks submit a
1226 responsive bid.

1227 (j) The agency shall procure at least two plans and up to
1228 four plans for Region 10. At least one plan must be a provider
1229 service network if any provider service networks submit a
1230 responsive bid.

1231 (k) The agency shall procure at least five plans and up to
1232 ten plans for Region 11. At least one plan must be a provider

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1233 service network if any provider service networks submit a
1234 responsive bid.

1235
1236 If no provider service network submits a responsive bid, the
1237 agency shall procure no more than one less than the maximum
1238 number of eligible plans permitted in that region. Within 12
1239 months after the initial invitation to negotiate, the agency
1240 shall attempt to procure a provider service network. The agency
1241 shall notice another invitation to negotiate only with provider
1242 service networks in those regions where no provider service
1243 network has been selected.

1244 (2) QUALITY SELECTION CRITERIA.—In addition to the
1245 criteria established in s. 409.966, the agency shall consider
1246 evidence that an eligible plan has written agreements or signed
1247 contracts or has made substantial progress in establishing
1248 relationships with providers before the plan submitting a
1249 response. The agency shall evaluate and give special weight to
1250 evidence of signed contracts with essential providers as defined
1251 by the agency pursuant to s. 409.975(2). The agency shall
1252 exercise a preference for plans with a provider network in which
1253 over 10 percent of the providers use electronic health records,
1254 as defined in s. 408.051. When all other factors are equal, the
1255 agency shall consider whether the organization has a contract to
1256 provide managed long-term care services in the same region and
1257 shall exercise a preference for such plans.

1258 (3) SPECIALTY PLANS.—Participation by specialty plans
1259 shall be subject to the procurement requirements and regional
1260 plan number limits of this section. However, a specialty plan

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1261 whose target population includes no more than 10 percent of the
1262 enrollees of that region is not subject to the regional plan
1263 number limits of this section.

1264 (4) CHILDREN'S MEDICAL SERVICES NETWORK.—Participation by
1265 the Children's Medical Services Network shall be pursuant to a
1266 single, statewide contract with the agency that is not subject
1267 to the procurement requirements or regional plan number limits
1268 of this section. The Children's Medical Services Network must
1269 meet all other plan requirements for the managed medical
1270 assistance program.

1271 Section 16. Section 409.975, Florida Statutes, is created
1272 to read:

1273 409.975 Managed care plan accountability.—In addition to
1274 the requirements of s. 409.967, plans and providers
1275 participating in the managed medical assistance program shall
1276 comply with the requirements of this section.

1277 (1) PROVIDER NETWORKS.—Managed care plans must develop and
1278 maintain provider networks that meet the medical needs of their
1279 enrollees in accordance with standards established pursuant to
1280 409.967(2) (b). Except as provided in this section, managed care
1281 plans may limit the providers in their networks based on
1282 credentials, quality indicators, and price.

1283 (a) Plans must include all providers in the region that
1284 are classified by the agency as essential Medicaid providers,
1285 unless the agency approves, in writing, an alternative
1286 arrangement for securing the types of services offered by the
1287 essential providers. Providers are essential for serving
1288 Medicaid enrollees if they offer services that are not available

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1289 from any other provider within a reasonable access standard, or
1290 if they provided a substantial share of the total units of a
1291 particular service used by Medicaid patients within the region
1292 during the last 3 years and the combined capacity of other
1293 service providers in the region is insufficient to meet the
1294 total needs of the Medicaid patients. The agency may not
1295 classify physicians and other practitioners as essential
1296 providers. The agency, at a minimum, shall determine which
1297 providers in the following categories are essential Medicaid
1298 providers:

1299 1. Federally qualified health centers.

1300 2. Statutory teaching hospitals as defined in s.
1301 408.07(45).

1302 3. Hospitals that are trauma centers as defined in s.
1303 395.4001(14).

1304 4. Hospitals located at least 25 miles from any other
1305 hospital with similar services.

1306
1307 Managed care plans that have not contracted with all essential
1308 providers in the region as of the first date of recipient
1309 enrollment, or with whom an essential provider has terminated
1310 its contract, must negotiate in good faith with such essential
1311 providers for 1 year or until an agreement is reached, whichever
1312 is first. Payments for services rendered by a nonparticipating
1313 essential provider shall be made at the applicable Medicaid rate
1314 as of the first day of the contract between the agency and the
1315 plan. A rate schedule for all essential providers shall be
1316 attached to the contract between the agency and the plan. After

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1 year, managed care plans that are unable to contract with essential providers shall notify the agency and propose an alternative arrangement for securing the essential services for Medicaid enrollees. The arrangement must rely on contracts with other participating providers, regardless of whether those providers are located within the same region as the nonparticipating essential service provider. If the alternative arrangement is approved by the agency, payments to nonparticipating essential providers after the date of the agency's approval shall equal 90 percent of the applicable Medicaid rate. If the alternative arrangement is not approved by the agency, payment to nonparticipating essential providers shall equal 110 percent of the applicable Medicaid rate.

(b) Certain providers are statewide resources and essential providers for all managed care plans in all regions. All managed care plans must include these essential providers in their networks. Statewide essential providers include:

1. Faculty plans of Florida medical schools.
2. Regional perinatal intensive care centers as defined in s. 383.16(2).
3. Hospitals licensed as specialty children's hospitals as defined in s. 395.002(28).
4. Accredited and integrated systems serving medically complex children that are comprised of separately licensed, but commonly owned, health care providers delivering at least the following services: medical group home, in-home and outpatient nursing care and therapies, pharmacy services, durable medical equipment, and Prescribed Pediatric Extended Care.

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1345
1346 Managed care plans that have not contracted with all statewide
1347 essential providers in all regions as of the first date of
1348 recipient enrollment must continue to negotiate in good faith.
1349 Payments to physicians on the faculty of nonparticipating
1350 Florida medical schools shall be made at the applicable Medicaid
1351 rate. Payments for services rendered by a regional perinatal
1352 intensive care centers shall be made at the applicable Medicaid
1353 rate as of the first day of the contract between the agency and
1354 the plan. Payments to nonparticipating specialty children's
1355 hospitals shall equal the highest rate established by contract
1356 between that provider and any other Medicaid managed care plan.

1357 (c) After 12 months of active participation in a plan's
1358 network, the plan may exclude any essential provider from the
1359 network for failure to meet quality or performance criteria. If
1360 the plan excludes an essential provider from the plan, the plan
1361 must provide written notice to all recipients who have chosen
1362 that provider for care. The notice shall be provided at least 30
1363 days before the effective date of the exclusion.

1364 (d) Each managed care plan must offer a network contract
1365 to each home medical equipment and supplies provider in the
1366 region which meets quality and fraud prevention and detection
1367 standards established by the plan and which agrees to accept the
1368 lowest price previously negotiated between the plan and another
1369 such provider.

1370 (2) FLORIDA MEDICAL SCHOOLS QUALITY NETWORK.—The agency
1371 shall contract with a single organization representing medical
1372 schools and graduate medical education programs in the state for

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1373 the purpose of establishing an active and ongoing program to
1374 improve clinical outcomes in all managed care plans. Contracted
1375 activities must support greater clinical integration for
1376 Medicaid enrollees through interdependent and cooperative
1377 efforts of all providers participating in managed care plans.
1378 The agency shall support these activities with certified public
1379 expenditures and any earned federal matching funds and shall
1380 seek any plan amendments or waivers necessary to comply with
1381 this subsection. To be eligible to participate in the quality
1382 network, a medical school must contract with each managed care
1383 plan in its region.

1384 (3) PERFORMANCE MEASUREMENT.—Each managed care plan shall
1385 monitor the quality and performance of each participating
1386 provider. At the beginning of the contract period, each plan
1387 shall notify all its network providers of the metrics used by
1388 the plan for evaluating the provider's performance and
1389 determining continued participation in the network.

1390 (4) MOMCARE NETWORK.—

1391 (a) The agency shall contract with an administrative
1392 services organization representing all Healthy Start Coalitions
1393 providing risk appropriate care coordination and other services
1394 in accordance with a federal waiver and pursuant to s. 409.906.
1395 The contract shall require the network of coalitions to provide
1396 counseling, education, risk-reduction and case management
1397 services, and quality assurance for all enrollees of the waiver.
1398 The agency shall evaluate the impact of the MomCare network by
1399 monitoring each plan's performance on specific measures to
1400 determine the adequacy, timeliness, and quality of services for

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1401 pregnant women and infants. The agency shall support this
1402 contract with certified public expenditures of general revenue
1403 appropriated for Healthy Start services and any earned federal
1404 matching funds.

1405 (b) Each managed care plan shall establish specific
1406 programs and procedures to improve pregnancy outcomes and infant
1407 health, including, but not limited to, coordination with the
1408 Healthy Start program, immunization programs, and referral to
1409 the Special Supplemental Nutrition Program for Women, Infants,
1410 and Children, and the Children's Medical Services program for
1411 children with special health care needs. Each plan's programs
1412 and procedures shall include agreements with each local Healthy
1413 Start Coalition in the region to provide risk-appropriate care
1414 coordination for pregnant women and infants, consistent with
1415 agency policies and the MomCare network. Each managed care plan
1416 must notify the agency of the impending birth of a child to an
1417 enrollee, or notify the agency as soon as practicable after the
1418 child's birth.

1419 (5) SCREENING RATE.—After the end of the second contract
1420 year, each managed care plan shall achieve an annual Early and
1421 Periodic Screening, Diagnosis, and Treatment Service screening
1422 rate of at least 80 percent of those recipients continuously
1423 enrolled for at least 8 months.

1424 (6) PROVIDER PAYMENT.—Managed care plans and hospitals
1425 shall negotiate mutually acceptable rates, methods, and terms of
1426 payment. For rates, methods, and terms of payment negotiated
1427 after the contract between the agency and the plan is executed,
1428 plans shall pay hospitals, at a minimum, the rate the agency

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1429 would have paid on the first day of the contract between the
1430 provider and the plan. Such payments to hospitals may not exceed
1431 120 percent of the rate the agency would have paid on the first
1432 day of the contract between the provider and the plan, unless
1433 specifically approved by the agency. Payment rates may be
1434 updated periodically.

1435 (7) MEDICALLY NEEDY ENROLLEES.—Each managed care plan must
1436 accept any medically needy recipient who selects or is assigned
1437 to the plan and provide that recipient with continuous
1438 enrollment for 12 months. After the first month of qualifying as
1439 a medically needy recipient and enrolling in a plan, and
1440 contingent upon federal approval, the enrollee shall pay the
1441 plan a portion of the monthly premium equal to the enrollee's
1442 share of the cost as determined by the department. The agency
1443 shall pay any remaining portion of the monthly premium. Plans
1444 are not obligated to pay claims for medically needy patients for
1445 services provided before enrollment in the plan. Medically needy
1446 patients are responsible for payment of incurred claims that are
1447 used to determine eligibility. Plans must provide a grace period
1448 of at least 90 days before disenrolling recipients who fail to
1449 pay their shares of the premium.

1450 Section 17. Section 409.976, Florida Statutes, is created
1451 to read:

1452 409.976 Managed care plan payment.—In addition to the
1453 payment provisions of s. 409.968, the agency shall provide
1454 payment to plans in the managed medical assistance program
1455 pursuant to this section.

1456 (1) Prepaid payment rates shall be negotiated between the

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1457 agency and the eligible plans as part of the procurement process
1458 described in s. 409.966.

1459 (2) The agency shall establish payment rates for statewide
1460 inpatient psychiatric programs. Payments to managed care plans
1461 shall be reconciled to reimburse actual payments to statewide
1462 inpatient psychiatric programs.

1463 Section 18. Section 409.977, Florida Statutes, is created
1464 to read:

1465 409.977 Enrollment.—

1466 (1) The agency shall automatically enroll into a managed
1467 care plan those Medicaid recipients who do not voluntarily
1468 choose a plan pursuant to s. 409.969. The agency shall
1469 automatically enroll recipients in plans that meet or exceed the
1470 performance or quality standards established pursuant to s.
1471 409.967 and may not automatically enroll recipients in a plan
1472 that is deficient in those performance or quality standards.
1473 When a specialty plan is available to accommodate a specific
1474 condition or diagnosis of a recipient, the agency shall assign
1475 the recipient to that plan. In the first year of the first
1476 contract term only, if a recipient was previously enrolled in a
1477 plan that is still available in the region, the agency shall
1478 automatically enroll the recipient in that plan unless an
1479 applicable specialty plan is available. Except as otherwise
1480 provided in this part, the agency may not engage in practices
1481 that are designed to favor one managed care plan over another.

1482 (2) When automatically enrolling recipients in managed
1483 care plans, the agency shall automatically enroll based on the
1484 following criteria:

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1485 (a) Whether the plan has sufficient network capacity to
1486 meet the needs of the recipients.

1487 (b) Whether the recipient has previously received services
1488 from one of the plan's primary care providers.

1489 (c) Whether primary care providers in one plan are more
1490 geographically accessible to the recipient's residence than
1491 those in other plans.

1492 (3) A newborn of a mother enrolled in a plan at the time
1493 of the child's birth shall be enrolled in the mother's plan.
1494 Upon birth, such a newborn is deemed enrolled in the managed
1495 care plan, regardless of the administrative enrollment
1496 procedures, and the managed care plan is responsible for
1497 providing Medicaid services to the newborn. The mother may
1498 choose another plan for the newborn within 90 days after the
1499 child's birth.

1500 (4) The agency shall develop a process to enable a
1501 recipient with access to employer-sponsored health care coverage
1502 to opt out of all managed care plans and to use Medicaid
1503 financial assistance to pay for the recipient's share of the
1504 cost in such employer-sponsored coverage. Contingent upon
1505 federal approval, the agency shall also enable recipients with
1506 access to other insurance or related products providing access
1507 to health care services created pursuant to state law, including
1508 any product available under the Florida Health Choices Program,
1509 or any health exchange, to opt out. The amount of financial
1510 assistance provided for each recipient may not exceed the amount
1511 of the Medicaid premium that would have been paid to a managed
1512 care plan for that recipient. The agency shall seek federal

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approval to require Medicaid recipients with access to employer-sponsored health care coverage to enroll in that coverage and use Medicaid financial assistance to pay for the recipient's share of the cost for such coverage. The amount of financial assistance provided for each recipient may not exceed the amount of the Medicaid premium that would have been paid to a managed care plan for that recipient.

Section 19. Section 409.978, Florida Statutes, is created to read:

409.978 Long-term care managed care program.—

(1) Pursuant to s. 409.963, the agency shall administer the long-term care managed care program described in ss. 409.978-409.985, but may delegate specific duties and responsibilities for the program to the Department of Elderly Affairs and other state agencies. By July 1, 2012, the agency shall begin implementation of the statewide long-term care managed care program, with full implementation in all regions by October 1, 2013.

(2) The agency shall make payments for long-term care, including home and community-based services, using a managed care model. Unless otherwise specified, ss. 409.961-409.97 apply to the long-term care managed care program.

(3) The Department of Elderly Affairs shall assist the agency to develop specifications for use in the invitation to negotiate and the model contract, determine clinical eligibility for enrollment in managed long-term care plans, monitor plan performance and measure quality of service delivery, assist clients and families to address complaints with the plans,

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1541 facilitate working relationships between plans and providers
1542 serving elders and disabled adults, and perform other functions
1543 specified in a memorandum of agreement.

1544 Section 20. Section 409.979, Florida Statutes, is created
1545 to read:

1546 409.979 Eligibility.—

1547 (1) Medicaid recipients who meet all of the following
1548 criteria are eligible to receive long-term care services and
1549 must receive long-term care services by participating in the
1550 long-term care managed care program. The recipient must be:

1551 (a) Sixty-five years of age or older, or age 18 or older
1552 and eligible for Medicaid by reason of a disability.

1553 (b) Determined by the Comprehensive Assessment Review and
1554 Evaluation for Long-Term Care Services (CARES) Program to
1555 require nursing facility care as defined in s. 409.985(3).

1556 (2) Medicaid recipients who, on the date long-term care
1557 managed care plans become available in their region, reside in a
1558 nursing home facility or are enrolled in one of the following
1559 long-term care Medicaid waiver programs are eligible to
1560 participate in the long-term care managed care program for up to
1561 12 months without being reevaluated for their need for nursing
1562 facility care as defined in s. 409.985(3):

1563 (a) The Assisted Living for the Frail Elderly Waiver.

1564 (b) The Aged and Disabled Adult Waiver.

1565 (c) The Adult Day Health Care Waiver.

1566 (d) The Consumer-Directed Care Plus Program as described
1567 in s. 409.221.

1568 (e) The Program of All-inclusive Care for the Elderly.

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1569 (f) The long-term care community-based diversion pilot
1570 project as described in s. 430.705.

1571 (g) The Channeling Services Waiver for Frail Elders.

1572 (3) The Department of Elderly Affairs shall make offers
1573 for enrollment to eligible individuals based on a wait-list
1574 prioritization and subject to availability of funds. Before
1575 enrollment offers, the department shall determine that
1576 sufficient funds exist to support additional enrollment into
1577 plans.

1578 Section 21. Section 409.98, Florida Statutes, is created
1579 to read:

1580 409.98 Long-term care plan benefits.—Long-term care plans
1581 shall, at a minimum, cover the following:

1582 (1) Nursing facility care.

1583 (2) Services provided in assisted living facilities.

1584 (3) Hospice.

1585 (4) Adult day care.

1586 (5) Medical equipment and supplies, including incontinence
1587 supplies.

1588 (6) Personal care.

1589 (7) Home accessibility adaptation.

1590 (8) Behavior management.

1591 (9) Home-delivered meals.

1592 (10) Case management.

1593 (11) Therapies:

1594 (a) Occupational therapy.

1595 (b) Speech therapy.

1596 (c) Respiratory therapy.

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1597 (d) Physical therapy.

1598 (12) Intermittent and skilled nursing.

1599 (13) Medication administration.

1600 (14) Medication management.

1601 (15) Nutritional assessment and risk reduction.

1602 (16) Caregiver training.

1603 (17) Respite care.

1604 (18) Transportation.

1605 (19) Personal emergency response system.

1606 Section 22. Section 409.981, Florida Statutes, is created
1607 to read:

1608 409.981 Eligible long-term care plans.—

1609 (1) ELIGIBLE PLANS.—Provider service networks must be
1610 long-term care provider service networks. Other eligible plans
1611 may be long-term care plans or comprehensive long-term care
1612 plans.

1613 (2) ELIGIBLE PLAN SELECTION.—The agency shall select
1614 eligible plans through the procurement process described in s.
1615 409.966. The agency shall provide notice of invitations to
1616 negotiate by July 1, 2012. The agency shall procure:

1617 (a) Two plans for Region 1. At least one plan must be a
1618 provider service network if any provider service networks submit
1619 a responsive bid.

1620 (b) Two plans for Region 2. At least one plan must be a
1621 provider service network if any provider service networks submit
1622 a responsive bid.

1623 (c) At least three plans and up to five plans for Region
1624 3. At least one plan must be a provider service network if any

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provider service networks submit a responsive bid.

(d) At least three plans and up to five plans for Region 4. At least one plan must be a provider service network if any provider service network submits a responsive bid.

(e) At least two plans and up to 4 plans for Region 5. At least one plan must be a provider service network if any provider service networks submit a responsive bid.

(f) At least four plans and up to seven plans for Region 6. At least one plan must be a provider service network if any provider service networks submit a responsive bid.

(g) At least three plans and up to 6 plans for Region 7. At least one plan must be a provider service networks if any provider service networks submit a responsive bid.

(h) At least two plans and up to four plans for Region 8. At least one plan must be a provider service network if any provider service networks submit a responsive bid.

(i) At least two plans and up to four plans for Region 9. At least one plan must be a provider service network if any provider service networks submit a responsive bid.

(j) At least two plans and up to four plans for Region 10. At least one plan must be a provider service network if any provider service networks submit a responsive bid.

(k) At least five plans and up to ten plans for Region 11. At least one plan must be a provider service network if any provider service networks submit a responsive bid.

If no provider service network submits a responsive bid in a region other than Region 1 or Region 2, the agency shall procure

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no more than one less than the maximum number of eligible plans permitted in that region. Within 12 months after the initial invitation to negotiate, the agency shall attempt to procure a provider service network. The agency shall notice another invitation to negotiate only with provider service networks in regions where no provider service network has been selected.

(3) QUALITY SELECTION CRITERIA.—In addition to the criteria established in s. 409.966, the agency shall consider the following factors in the selection of eligible plans:

(a) Evidence of the employment of executive managers with expertise and experience in serving aged and disabled persons who require long-term care.

(b) Whether a plan has established a network of service providers dispersed throughout the region and in sufficient numbers to meet specific service standards established by the agency for specialty services for persons receiving home and community-based care.

(c) Whether a plan is proposing to establish a comprehensive long-term care plan and whether the eligible plan has a contract to provide managed medical assistance services in the same region.

(d) Whether a plan offers consumer-directed care services to enrollees pursuant to s. 409.221.

(e) Whether a plan is proposing to provide home and community-based services in addition to the minimum benefits required by s. 409.98.

(4) PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY.—
Participation by the Program of All-Inclusive Care for the

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1681 Elderly (PACE) shall be pursuant to a contract with the agency
1682 and not subject to the procurement requirements or regional plan
1683 number limits of this section. PACE plans may continue to
1684 provide services to individuals at such levels and enrollment
1685 caps as authorized by the General Appropriations Act.

1686 (5) MEDICARE PLANS.—Participation by a Medicare Advantage
1687 Preferred Provider Organization, Medicare Advantage Provider-
1688 sponsored Organization, or Medicare Advantage Special Needs Plan
1689 shall be pursuant to a contract with the agency and not subject
1690 to the procurement requirements if the plan's Medicaid enrollees
1691 consist exclusively of recipients who are deemed dually eligible
1692 for Medicaid and Medicare services. Otherwise, Medicare
1693 Advantage Preferred Provider Organizations, Medicare Advantage
1694 Provider-Sponsored Organizations, and Medicare Advantage Special
1695 Needs Plans are subject to all procurement requirements.

1696 Section 23. Section 409.982, Florida Statutes, is created
1697 to read:

1698 409.982 Long-term care managed care plan accountability.—
1699 In addition to the requirements of s. 409.967, plans and
1700 providers participating in the long-term care managed care
1701 program must comply with the requirements of this section.

1702 (1) PROVIDER NETWORKS.—Managed care plans may limit the
1703 providers in their networks based on credentials, quality
1704 indicators, and price. For the period between October 1, 2013,
1705 and September 30, 2014, each selected plan must offer a network
1706 contract to all the following providers in the region:

1707 (a) Nursing homes.

1708 (b) Hospices.

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1709 (c) Aging network service providers that have previously
1710 participated in home and community-based waivers serving elders
1711 or community-service programs administered by the Department of
1712 Elderly Affairs.

1713
1714 After 12 months of active participation in a managed care plan's
1715 network, the plan may exclude any of the providers named in this
1716 subsection from the network for failure to meet quality or
1717 performance criteria. If the plan excludes a provider from the
1718 plan, the plan must provide written notice to all recipients who
1719 have chosen that provider for care. The notice must be provided
1720 at least 30 days before the effective date of the exclusion. The
1721 agency shall establish contract provisions governing the
1722 transfer of recipients from excluded residential providers.

1723 (2) SELECT PROVIDER PARTICIPATION.—Except as provided in
1724 this subsection, providers may limit the managed care plans they
1725 join. Nursing homes and hospices that are enrolled Medicaid
1726 providers must participate in all eligible plans selected by the
1727 agency in the region in which the provider is located.

1728 (3) PERFORMANCE MEASUREMENT.—Each managed care plan shall
1729 monitor the quality and performance of each participating
1730 provider using measures adopted by and collected by the agency
1731 and any additional measures mutually agreed upon by the provider
1732 and the plan

1733 (4) PROVIDER NETWORK STANDARDS.—The agency shall establish
1734 and each managed care plan must comply with specific standards
1735 for the number, type, and regional distribution of providers in
1736 the plan's network, which must include:

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1737 (a) Adult day care centers.
 1738 (b) Adult family-care homes.
 1739 (c) Assisted living facilities.
 1740 (d) Health care services pools.
 1741 (e) Home health agencies.
 1742 (f) Homemaker and companion services.
 1743 (g) Hospices.
 1744 (h) Community care for the elderly lead agencies.
 1745 (i) Nurse registries.
 1746 (j) Nursing homes.
 1747 (5) PROVIDER PAYMENT.—Managed care plans and providers
 1748 shall negotiate mutually acceptable rates, methods, and terms of
 1749 payment. Plans shall pay nursing homes an amount equal to the
 1750 nursing facility-specific payment rates set by the agency;
 1751 however, mutually acceptable higher rates may be negotiated for
 1752 medically complex care. Plans shall pay hospice providers
 1753 through a prospective system for each enrollee an amount equal
 1754 to the per diem rate set by the agency. For recipients residing
 1755 in a nursing facility and receiving hospice services, the plan
 1756 shall pay the hospice provider the per diem rate set by the
 1757 agency minus the nursing facility component and shall pay the
 1758 nursing facility the applicable state rate. Plans must ensure
 1759 that electronic nursing home and hospice claims that contain
 1760 sufficient information for processing are paid within 10
 1761 business days after receipt.
 1762 Section 24. Section 409.983, Florida Statutes, is created
 1763 to read:
 1764 409.983 Long-term care managed care plan payment.—In

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1765 addition to the payment provisions of s. 409.968, the agency
1766 shall provide payment to plans in the long-term care managed
1767 care program pursuant to this section.

1768 (1) Prepaid payment rates for long-term care managed care
1769 plans shall be negotiated between the agency and the eligible
1770 plans as part of the procurement process described in s.
1771 409.966.

1772 (2) Payment rates for comprehensive long-term care plans
1773 covering services described in s. 409.973 shall be blended with
1774 rates for long-term care plans for services specified in s.
1775 409.98.

1776 (3) Payment rates for plans must reflect historic
1777 utilization and spending for covered services projected forward
1778 and adjusted to reflect the level of care profile for enrollees
1779 in each plan. The payment shall be adjusted to provide an
1780 incentive for reducing institutional placements and increasing
1781 the utilization of home and community-based services.

1782 (4) The initial assessment of an enrollee's level of care
1783 shall be made by the Comprehensive Assessment and Review for
1784 Long-Term-Care Services (CARES) program, which shall assign the
1785 recipient into one of the following levels of care:

1786 (a) Level of care 1 consists of recipients residing in or
1787 who must be placed in a nursing home.

1788 (b) Level of care 2 consists of recipients at imminent
1789 risk of nursing home placement, as evidenced by the need for the
1790 constant availability of routine medical and nursing treatment
1791 and care, and require extensive health-related care and services
1792 because of mental or physical incapacitation.

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1793 (c) Level of care 3 consists of recipients at imminent
1794 risk of nursing home placement, as evidenced by the need for the
1795 constant availability of routine medical and nursing treatment
1796 and care, who have a limited need for health-related care and
1797 services and are mildly medically or physically incapacitated.

1798
1799 The agency shall periodically adjust payment rates to account
1800 for changes in the level of care profile for each managed care
1801 plan based on encounter data.

1802 (5) The agency shall make an incentive adjustment in
1803 payment rates to encourage the increased utilization of home and
1804 community-based services and a commensurate reduction of
1805 institutional placement. The incentive adjustment shall be
1806 modified in each successive rate period during the first
1807 contract period, as follows:

1808 (a) A 2 percentage point shift in the first rate-setting
1809 period;

1810 (b) A 2 percentage point shift in the second rate-setting
1811 period, as compared to the utilization mix at the end of the
1812 first rate-setting period; or

1813 (c) A 3 percentage point shift in the third rate-setting
1814 period, and in each subsequent rate-setting period during the
1815 first contract period, as compared to the utilization mix at the
1816 end of the immediately preceding rate-setting period.

1817
1818 The incentive adjustment shall continue in subsequent contract
1819 periods, at a rate of 3 percentage points per year as compared
1820 to the utilization mix at the end of the immediately preceding

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1821 rate-setting period, until no more than 35 percent of the plan's
1822 enrollees are placed in institutional settings. The agency shall
1823 annually report to the Legislature the actual change in the
1824 utilization mix of home and community-based services compared to
1825 institutional placements and provide a recommendation for
1826 utilization mix requirements for future contracts.

1827 (6) The agency shall establish nursing-facility-specific
1828 payment rates for each licensed nursing home based on facility
1829 costs adjusted for inflation and other factors as authorized in
1830 the General Appropriations Act. Payments to long-term care
1831 managed care plans shall be reconciled to reimburse actual
1832 payments to nursing facilities.

1833 (7) The agency shall establish hospice payment rates
1834 pursuant to Title XVIII of the Social Security Act. Payments to
1835 long-term care managed care plans shall be reconciled to
1836 reimburse actual payments to hospices.

1837 Section 25. Section 409.984, Florida Statutes, is created
1838 to read:

1839 409.984 Enrollment in a long-term care managed care plan.—

1840 (1) The agency shall automatically enroll into a long-term
1841 care managed care plan those Medicaid recipients who do not
1842 voluntarily choose a plan pursuant to s. 409.969. The agency
1843 shall automatically enroll recipients in plans that meet or
1844 exceed the performance or quality standards established pursuant
1845 to s. 409.967 and may not automatically enroll recipients in a
1846 plan that is deficient in those performance or quality
1847 standards. If a recipient is deemed dually eligible for Medicaid
1848 and Medicare services and is currently receiving Medicare

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1849 services from an entity qualified under 42 C.F.R. part 422 as a
1850 Medicare Advantage Preferred Provider Organization, Medicare
1851 Advantage Provider-sponsored Organization, or Medicare Advantage
1852 Special Needs Plan, the agency shall automatically enroll the
1853 recipient in such plan for Medicaid services if the plan is
1854 currently participating in the long-term care managed care
1855 program. Except as otherwise provided in this part, the agency
1856 may not engage in practices that are designed to favor one
1857 managed care plan over another.

1858 (1) When automatically enrolling recipients in plans, the
1859 agency shall take into account the following criteria:

1860 (a) Whether the plan has sufficient network capacity to
1861 meet the needs of the recipients.

1862 (b) Whether the recipient has previously received services
1863 from one of the plan's home and community-based service
1864 providers.

1865 (c) Whether the home and community-based providers in one
1866 plan are more geographically accessible to the recipient's
1867 residence than those in other plans.

1868 (3) Notwithstanding s. 409.969(3)(c), if a recipient is
1869 referred for hospice services, the recipient has 30 days during
1870 which the recipient may select to enroll in another managed care
1871 plan to access the hospice provider of the recipient's choice.

1872 (4) If a recipient is referred for placement in a nursing
1873 home or assisted living facility, the plan must inform the
1874 recipient of any facilities within the plan that have specific
1875 cultural or religious affiliations and, if requested by the
1876 recipient, make a reasonable effort to place the recipient in

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the facility of the recipient's choice.

Section 26. Section 409.9841, Florida Statutes, is created to read:

409.9841 Long-term care managed care technical advisory workgroup.—

(1) Before August 1, 2011, the agency shall establish a technical advisory workgroup to assist in developing:

(a) The method of determining Medicaid eligibility pursuant to s. 409.985(3).

(b) The requirements for provider payments to nursing homes under s. 409.983(6).

(c) The method for managing Medicare coinsurance crossover claims.

(d) Uniform requirements for claims submissions and payments, including electronic funds transfers and claims processing.

(e) The process for enrollment of and payment for individuals pending determination of Medicaid eligibility.

(2) The advisory workgroup must include, but is not limited to, representatives of providers and plans who could potentially participate in long-term care managed care. Members of the workgroup shall serve without compensation but may be reimbursed for per diem and travel expenses as provided in s. 112.061.

(3) This section is repealed on June 30, 2013.

Section 27. Section 409.985, Florida Statutes, is created to read:

409.985 Comprehensive Assessment and Review for Long-Term

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Care Services (CARES) Program.—

(1) The agency shall operate the Comprehensive Assessment and Review for Long-Term Care Services (CARES) preadmission screening program to ensure that only individuals whose conditions require long-term care services are enrolled in the long-term care managed care program.

(2) The agency shall operate the CARES program through an interagency agreement with the Department of Elderly Affairs. The agency, in consultation with the Department of Elderly Affairs, may contract for any function or activity of the CARES program, including any function or activity required by 42 C.F.R. part 483.20, relating to preadmission screening and review.

(3) The CARES program shall determine if an individual requires nursing facility care and, if the individual requires such care, assign the individual to a level of care as described in s. 409.983(4). When determining the need for nursing facility care, consideration shall be given to the nature of the services prescribed and which level of nursing or other health care personnel meets the qualifications necessary to provide such services and the availability to and access by the individual of community or alternative resources. For the purposes of the long-term care managed care program, the term "nursing facility care" means the individual:

(a) Requires nursing home placement as evidenced by the need for medical observation throughout a 24-hour period and care required to be performed on a daily basis by, or under the direct supervision of, a registered nurse or other health care

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professional and requires services that are sufficiently medically complex to require supervision, assessment, planning, or intervention by a registered nurse because of a mental or physical incapacitation by the individual;

(b) Requires or is at imminent risk of nursing home placement as evidenced by the need for observation throughout a 24-hour period and care and the constant availability of medical and nursing treatment and requires services on a daily or intermittent basis that are to be performed under the supervision of licensed nursing or other health professionals because the individual who is incapacitated mentally or physically; or

(c) Requires or is at imminent risk of nursing home placement as evidenced by the need for observation throughout a 24-hour period and care and the constant availability of medical and nursing treatment and requires limited services that are to be performed under the supervision of licensed nursing or other health professionals because the individual is mildly incapacitated mentally or physically.

(4) For individuals whose nursing home stay is initially funded by Medicare and Medicare coverage and is being terminated for lack of progress towards rehabilitation, CARES staff shall consult with the person making the determination of progress toward rehabilitation to ensure that the recipient is not being inappropriately disqualified from Medicare coverage. If, in their professional judgment, CARES staff believe that a Medicare beneficiary is still making progress toward rehabilitation, they may assist the Medicare beneficiary with an appeal of the

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disqualification from Medicare coverage. The use of CARES teams to review Medicare denials for coverage under this section is authorized only if it is determined that such reviews qualify for federal matching funds through Medicaid. The agency shall seek or amend federal waivers as necessary to implement this section.

Section 28. If any provision of this act or its application to any person or circumstance is held invalid, the invalidity does not affect other provisions or applications of the act which can be given effect without the invalid provision or application, and to this end the provisions of this act are severable.

Section 29. This act shall take effect July 1, 2011.